



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA Texas
Valley Coastal Bend Health
Care System in Harlingen



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Figure 1. Harlingen VA Clinic in Texas.

Source: “Facilities Locator & Leadership Directory, VA Texas Valley Coastal Bend Health Care System,” VA website.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the outpatient settings of the VA Texas Valley Coastal Bend Health Care System, which includes its main location in Harlingen and multiple clinics in South Texas. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)¹

The OIG conducted an unannounced virtual inspection of the VA Texas Valley Coastal Bend Health Care System during the week of January 10, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

¹ The OIG did not perform this review at the VA Texas Valley Coastal Bend Health Care System because it did not have an emergency department or urgent care center.

Conclusion

The OIG conducted a detailed inspection of key clinical and administrative processes associated with promoting quality care. The OIG did not issue any recommendations related to the areas reviewed for this report.

VA Comments

The Veterans Integrated Service Network Director and System Director concurred with the report (see appendixes B and C, pages 17–18).



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the outpatient settings of the VA Texas Valley Coastal Bend Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.¹

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.² Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”³

To examine risks to patients and the organization, the OIG focused on core processes in the following areas of clinical and administrative operations:⁴

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)⁵

¹ VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

² Anam Parand et al., “The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review,” *British Medical Journal* 4, no. 9 (September 5, 2014), <https://doi.org/10.1136/bmjopen-2014-005055>.

³ Danae F. Sfantou et al., “Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

⁴ CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

⁵ The OIG did not perform this review at the VA Texas Valley Coastal Bend Health Care System because it did not have an emergency department or urgent care center.

Methodology

The VA Texas Valley Coastal Bend Health Care System provides care through its main location in Harlingen and associated outpatient clinics in South Texas. General information about the healthcare system can be found in appendix A.

The inspection team examined operations from May 9, 2019, through January 14, 2022, the last day of the unannounced multiday evaluation.⁶ During the virtual visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁷ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁶ The OIG's last comprehensive healthcare inspection of the VA Texas Valley Coastal Bend Health Care System occurred in May 2019. The Joint Commission performed ambulatory, behavioral health care and human services, and home care accreditation reviews in December 2020.

⁷ Inspector General (IG) Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24).

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.⁸ High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their vision and strategy, and “practice systems thinking and collaboration across boundaries.”⁹ When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.¹⁰

To assess this healthcare system’s leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders’ responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Associate Director, Associate Director for Patient Care Services, and Chief of Staff.¹¹ The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, executive team leaders had worked together for more than two and half years, except for the acting Chief of Staff who assumed the role in July 2021. The Director was permanently assigned in January 2019, the Associate Director in April 2019, and the Associate Director for Patient Care Services in July 2018.

⁸ Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

⁹ Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

¹⁰ Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

¹¹ The Deputy Chief of Staff was the acting Chief of Staff at the time of the OIG inspection.

Budget and Operations

The OIG noted that the healthcare system’s fiscal year (FY) 2021 annual medical care budget of \$495,604,252 had increased approximately 4.6 percent compared to the previous year’s budget of \$473,767,278.¹² The Director reported that leaders were hiring more specialists and expanding services, such as cardiology, to bring patient care back into the healthcare system from the community.

Employee Satisfaction

The All Employee Survey is an “annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.”¹³ The instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

The OIG reviewed results from VA’s All Employee Survey from FYs 2019 through 2021 regarding employees’ perceived ability to disclose a suspected violation without fear of reprisal.¹⁴

¹² Veterans Health Administration (VHA) Support Service Center.

¹³ “AES Survey History, Understanding Workplace Experiences in VA,” VHA Support Service Center website.

¹⁴ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders’ All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

Ability to Disclose a Suspected Violation

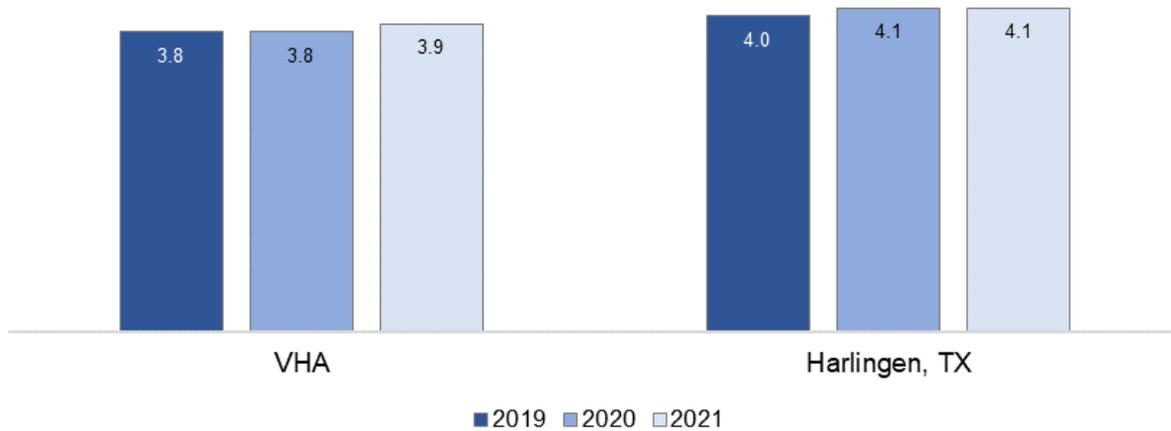


Figure 2. All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

Source: VA All Employee Survey (accessed December 7, 2021).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

Veterans Health Administration (VHA) uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and benchmark performance against the private sector. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.¹⁵

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁶ The OIG reviewed responses to two relevant survey questions that reflect outpatient experiences with the healthcare system from October 2017 (FY 2018), through August 2021. Figures 3 and 4 provide survey scores for VHA and the healthcare system over time.¹⁷

¹⁵ “Patient Experiences Survey Results,” VHA Support Service Center website.

¹⁶ The VA Texas Valley Coastal Bend Health Care System does not have inpatient services.

¹⁷ Scores are based on responses by patients who received outpatient care at the healthcare system.

Outpatient Patient-Centered Medical Home Satisfaction

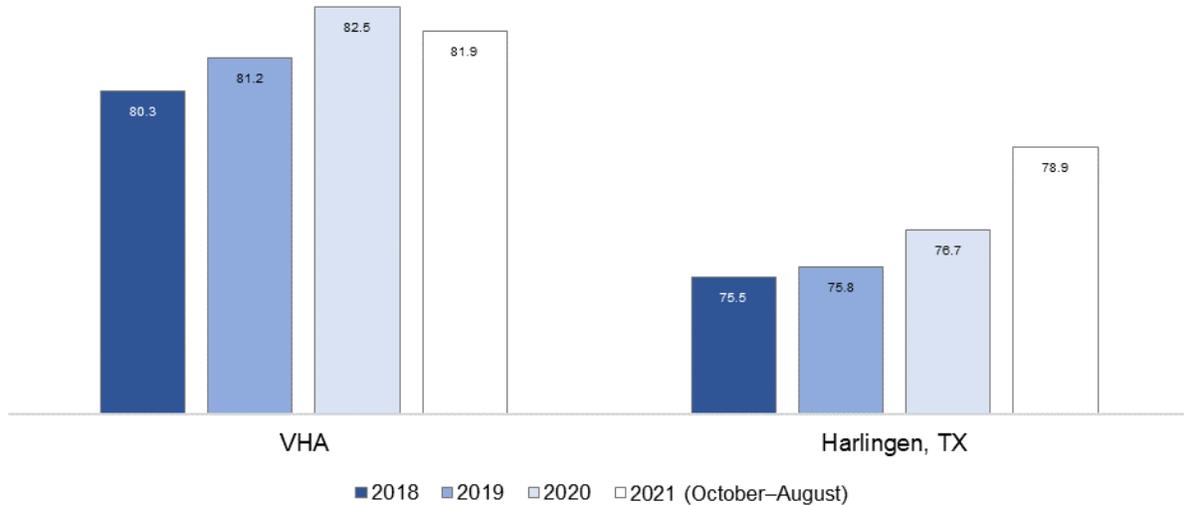


Figure 3. Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

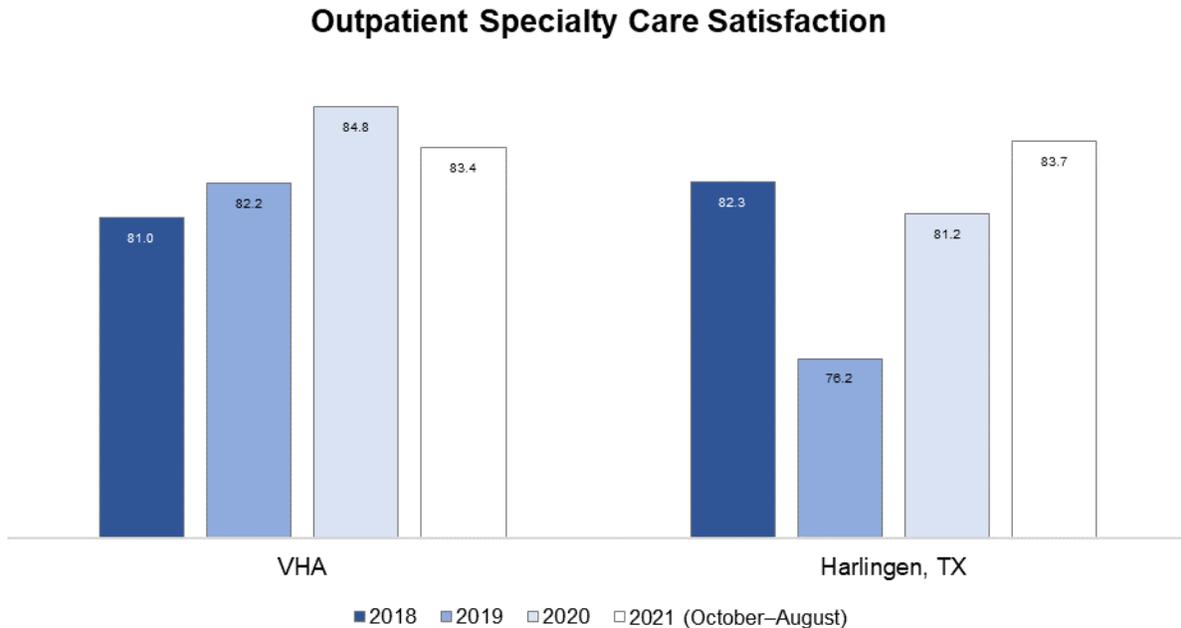


Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders’ Responses

Leaders must ensure that patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁸ The Joint Commission defines a sentinel event as an incident or condition that “results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life.”¹⁹ Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”²⁰ Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their

¹⁸ Frankel, *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁹ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

²⁰ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”²¹ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

Table 1 lists the system’s reported adverse patient safety events from May 9, 2019 (the prior OIG CHIP site visit), to January 10, 2022.

**Table 1. Adverse Patient Safety Events
(May 9, 2019, to January 10, 2022)**

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	7
Large-Scale Disclosures	0

Source: VA Texas Valley Coastal Bend Health Care System Chief of Quality Management (received January 11, 2022).

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.²² A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.²³

The Director and acting Chief of Staff stated that staff informed the executive leadership team of adverse patient safety events during daily morning huddles and of critical events throughout the day, evening, or weekend.²⁴ The Chief of Quality Management told the OIG that staff report patient safety events in different ways, including via email, through their supervisors, and by entries into the Joint Patient Safety Reporting system.²⁵

²¹ VHA Directive 1004.08.

²² The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

²³ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

²⁴ “Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers.” VHA Directive 1004.08.

²⁵ “In 2018, the Veterans Health Administration began using the Joint Patient Safety Reporting system or (JPSR) which standardizes event capture and data management on medical errors and close calls/near misses for the Military and Veterans Health Systems.” “VHA National Center for Patient Safety,” VA, accessed February 22, 2023, <https://www.patientsafety.va.gov/about/faqs.asp>.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience.”²⁶ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²⁷ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).²⁸

To determine whether staff at VHA facilities have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system’s committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system’s processes for conducting peer reviews of clinical care.²⁹ Peer reviews, “when conducted systematically and credibly,” reveal areas for improvement (involving one or more providers’ practices) and can result in both immediate and “long-term improvements in patient care.”³⁰ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.³¹

Finally, the OIG assessed the healthcare system’s culture of safety.³² VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

²⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²⁷ VHA Directive 1100.16. *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

²⁸ VHA Directive 1100.16.

²⁹ A peer review is a “critical review of care, performed by a peer,” to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

³⁰ VHA Directive 1190.

³¹ VHA Directive 1190.

³² A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/usersguide/hospitalusersguide.pdf>.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³³ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³⁴

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³⁵ LIPs are granted clinical privileges for no more than two years and must be repriviledged prior to their expiration.³⁶

VHA defines the Focused Professional Practice Evaluation as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance.”³⁷ The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.³⁸ Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.³⁹

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.⁴⁰ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

³³ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing portion of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³⁴ VHA Handbook 1100.19.

³⁵ VHA Handbook 1100.19.

³⁶ VHA Handbook 1100.19.

³⁷ VHA Handbook 1100.19.

³⁸ VHA Handbook 1100.19.

³⁹ VHA Handbook 1100.19.

⁴⁰ VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.⁴¹

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members who underwent clinical privileging in the previous 12 months.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

⁴¹ Assistant Under Secretary for Health for Operations memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.⁴² The physical environment of a healthcare organization must not only be functional but should also promote healing. The purpose of this inspection was to determine whether VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards.

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.⁴³ VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times during emergencies and contribute to a safe healthcare environment.⁴⁴

The OIG evaluated whether staff completed environment of care inspections and tracked issues until they were resolved. Additionally, the OIG evaluated the healthcare system's implementation of the Rapid Naloxone Initiative.

Environment of Care Findings and Recommendations

The OIG made no recommendations.

⁴² VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (This directive was rescinded and replaced with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

⁴³ Centers for Disease Control and Prevention – National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

⁴⁴ Opioids are medications that are “effective at reducing pain” but “when taken in excess, can lead to respiratory arrest.” Naloxone is a highly effective treatment for reversing an opioid overdose. “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed December 16, 2021, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>. “Pharmacy Benefits Management Services,” Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. The OIG conducted a detailed inspection of key clinical and administrative areas and did not issue any recommendations.

Appendix A: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated system reporting to VISN 17.¹

**Table A.1. Profile for VA Texas Valley Coastal Bend Health Care System (740)
(October 1, 2018, through September 30, 2021)**

Profile Element	System Data FY 2019*	System Data FY 2020†	System Data FY 2021‡
Total medical care budget	\$303,727,988	\$473,767,278	\$495,604,252
Number of:			
• Unique patients	37,721	40,434	44,065
• Outpatient visits	437,267	455,419	511,446
• Unique employees§	802	931	1,038

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

*October 1, 2018, through September 30, 2019.

†October 1, 2019, through September 30, 2020.

‡October 1, 2020, through September 30, 2021.

§Unique employees involved in direct medical care (cost center 8200).

¹ VHA medical facilities are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 13, 2023

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System in Harlingen

To: Director, Office of Healthcare Inspections (54CH03)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the Valley Coastal Bend VA Health Care System in Texas. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.

I have reviewed and concur with the report.

(Original signed by:)

Wendell Jones, MD MHA

Appendix C: Director Comments

Department of Veterans Affairs Memorandum

Date: March 6, 2023

From: Director, VA Texas Valley Coastal Bend Health Care System (740/00)

Subj: Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System in Harlingen

To: Director, VA Heart of Texas Health Care Network (10N17)

Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of January 10, 2022, at VA Texas Valley Coastal Bend Health Care System.

I have reviewed the document and concur with the report.

(Original signed by:)

Homero S. Martinez III, MBA

OIG Contact and Staff Acknowledgments

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